FACE TO FACE ENCOUNTER HOME CARE

To be completed by the Home Health Certifying Physician

Patient Name: _____

Patient Date of Birth: _____ Soc Date: _____

QUALIFYING ENCOUNTER

Face-to-face encounter must be completed on or after:

Within 90 days prior to SOC date: _____

or by Within 30 days prior to SOC date: _____

Actual Encounter Date: _____

or Scheduled Date: _____

PHYSICIAN ATTESTATION

Home Health Certifying Physician: _____

I certify that this patient is under my care and that I, or a nurse practioner/physician's assistant working with me, has had a face to face encounter that meets the physician face-to-face encounter requirements with this patient.

I certify that my clinical findings support that this patient is homebound.

I certify that the encounter with the patient was in whole, or in part, for the documented medical condition, which is the primary reason for home health care.

I certify that based on my clinical findings, the following are medically necessary home health services.

- □ AIDE
- □ Therapy
- □ Skilled Nursing

To provide the care and or treatments according to the Plan of Care that has been established and will be reviewed periodically.

I certify that the attached documentation/record supports home health certification and clearly indicates why patient is eligible for home health.

Physician Name: _____ Date: _____